

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0045377</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER	
Facility Name: <u>Prairie City Health Care Center</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>01/01/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.	
Address: <u>825 East Main Street</u> <u>Prairie City</u> <u>61470-9411</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.	
County: <u>McDonough</u>			
Telephone Number: <u>(309) 775-3313</u> Fax # <u>(309) 775-3311</u>			
IDPA ID Number: <u>371409457001</u>			
Date of Initial License for Current Owners: <u>4/30/01</u>			
Type of Ownership:			
<input type="checkbox"/> VOLUNTARY, NON-PROFIT		<input checked="" type="checkbox"/> PROPRIETARY	
<input type="checkbox"/> Charitable Corp.		<input type="checkbox"/> Individual	
<input type="checkbox"/> Trust		<input type="checkbox"/> State	
IRS Exemption Code _____		<input type="checkbox"/> Partnership	
		<input checked="" type="checkbox"/> Corporation	
		<input type="checkbox"/> "Sub-S" Corp.	
		<input type="checkbox"/> Limited Liability Co.	
		<input type="checkbox"/> Trust	
		<input type="checkbox"/> Other _____	
In the event there are further questions about this report, please contact: Name: <u>Eddie Franciskovich</u> Telephone Number: <u>(309) 775-3313</u>		Officer or Administrator of Provider (Signed) _____ (Date) _____ (Type or Print Name) <u>Eddie Franciskovich</u> (Title) <u>Administrator</u>	
		Paid Preparer (Signed) <u>See Accountant's Compilation Report</u> (Date) _____ (Print Name and Title) _____ (Firm Name & Address) <u>Ginoli & Company Ltd</u> <u>411 Hamilton Blvd., Ste 1616; Peoria, IL 61602-1104</u> (Telephone) <u>(309) 671-2350</u> Fax # <u>(309) 671-5459</u>	
		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	

SEE ACCOUNTANT'S COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds NA

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>0</u>	Skilled (SNF)	<u>48</u>	<u>3,312</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>48</u>	Intermediate (ICF)	<u>0</u>	<u>14,208</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>48</u>	TOTALS	<u>48</u>	<u>17,520</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>231</u>			<u>231</u>	8
9	SNF/PED					9
10	ICF	<u>4,879</u>	<u>4,245</u>		<u>9,124</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>5,110</u>	<u>4,245</u>		<u>9,355</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 53.40%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)None

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☒ NO ☐

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 04/30/01

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 04/30/01 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☐ NO ☒ If YES, enter number
of beds certified 0 and days of care provided NAMedicare Intermediary NA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED
CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number

Prairie City Health Care Center

0045377

Report Period Beginning:

01/01/02

Ending:

12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	75,580	6,054	2,330	83,964	(174)	83,790		83,790			1
2	Food Purchase		38,565		38,565		38,565		38,565			2
3	Housekeeping	43,778	6,647	126	50,551		50,551		50,551			3
4	Laundry	8,016	4,119	313	12,448	(313)	12,135		12,135			4
5	Heat and Other Utilities			17,367	17,367	223	17,590	101	17,691			5
6	Maintenance	21,010	46,079	8,553	75,642		75,642	181	75,823			6
7	Other (specify):*											7
8	TOTAL General Services	148,384	101,464	28,689	278,537	(264)	278,273	282	278,555			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	337,966	15,257	2,027	355,250		355,250		355,250			10
10a	Therapy		750	975	1,725		1,725		1,725			10a
11	Activities	31,772	294	506	32,572		32,572		32,572			11
12	Social Services	18,500	198	1,355	20,053		20,053		20,053			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	388,238	16,499	4,863	409,600		409,600		409,600			16
	C. General Administration											
17	Administrative	43,750	325		44,075		44,075		44,075			17
18	Directors Fees											18
19	Professional Services			46,632	46,632	(26,280)	20,352	(8,779)	11,573			19
20	Dues, Fees, Subscriptions & Promotions			11,816	11,816	(8,857)	2,959	136	3,095			20
21	Clerical & General Office Expenses	5,583	3,413	7,633	16,629	(763)	15,866	3,049	18,915			21
22	Employee Benefits & Payroll Taxes			106,518	106,518		106,518	3,478	109,996			22
23	Inservice Training & Education							113	113			23
24	Travel and Seminar			1,258	1,258		1,258	284	1,542			24
25	Other Admin. Staff Transportation			5,096	5,096		5,096	267	5,363			25
26	Insurance-Prop.Liab.Malpractice					33,666	33,666	409	34,075			26
27	Other (specify):*			10,422	10,422	(10,243)	179		179			27
28	TOTAL General Administration	49,333	3,738	189,375	242,446	(12,477)	229,969	(1,043)	228,926			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	585,955	121,701	222,927	930,583	(12,741)	917,842	(761)	917,081			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

STATE OF ILLINOIS

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Facility Name & ID Number Prairie City Health Care Center #0045377 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			36,872	36,872	(4,296)	32,576	(7,465)	25,111			30
31	Amortization of Pre-Op. & Org.			1,366	1,366		1,366		1,366			31
32	Interest			1,401	1,401	8,948	10,349	1,565	11,914			32
33	Real Estate Taxes			4,095	4,095		4,095		4,095			33
34	Rent-Facility & Grounds							607	607			34
35	Rent-Equipment & Vehicles			1,125	1,125	90	1,215	92	1,307			35
36	Other (specify):*			33,666	33,666	(33,666)						36
37	TOTAL Ownership			78,525	78,525	(28,924)	49,601	(5,201)	44,400			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,280	26,280		26,280			42
43	Other (specify):*					15,385	15,385	(15,385)				43
44	TOTAL Special Cost Centers					41,665	41,665	(15,385)	26,280			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	585,955	121,701	301,452	1,009,108		1,009,108	(21,347)	987,761			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377Report Period Beginning: 01/01/02Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(763)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(9,026)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(174)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance	(625)	43		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(8,857)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See attached Schedule pg 5A	(15,966)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (35,411)		\$	30

OHF USE ONLY						
48		49		50		51
						52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	14,064		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 14,064		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,347)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	\$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops	x		131	30	41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule	x		15,254		45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			\$ 15,385		47

SEE ACCOUNTANTS' COMPILATION REPORT

Prairie City Health Care Center

ID# 0045377

Report Period Beginning: 01/01/02

Ending: 12/31/02

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Beauty shop equipment depreciation	\$ (131)	43	1
2	Special events	(670)	43	2
3	Non-care auto depreciation	(4,165)	43	3
4	Management fees paid to related party	(11,000)	19	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(15,966)		49

Summary A

12/31/02

[illegible]

Summary B

12/31/02

[illegible]

Facility Name & ID Number Prairie City Health Care Center# 0045377

Report Period Beginning:

01/01/02

Ending:

12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Carolyn Petersen	See					
Eddie Franciskovich	Attached	See attached schedule		See attached schedule		
Mark Petersen	Schedule					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	5 Utilities	\$	Petersen Health Care Companies	0.00%	\$ 101	\$ 101 1
2	V	6 Maintenance Supplies		Petersen Health Care Companies	0.00%	181	181 2
3	V	19 Professional Services		Petersen Health Care Companies	0.00%	2,221	2,221 3
4	V	20 Dues, Fees and Subscriptions		Petersen Health Care Companies	0.00%	136	136 4
5	V	21 Clerical and General Office		Petersen Health Care Companies	0.00%	3,049	3,049 5
6	V	22 Employee Benefits		Petersen Health Care Companies	0.00%	3,478	3,478 6
7	V	23 Inservice Training		Petersen Health Care Companies	0.00%	113	113 7
8	V	24 Travel & Seminars		Petersen Health Care Companies	0.00%	284	284 8
9	V	25 Other Admin. Staff Transport		Petersen Health Care Companies	0.00%	267	267 9
10	V	26 Insurance		Petersen Health Care Companies	0.00%	409	409 10
11	V	30 Depreciation		Petersen Health Care Companies	0.00%	1,561	1,561 11
12	V	32 Interest		Petersen Health Care Companies	0.00%	1,565	1,565 12
13	V	34 Rent - Facility and Grounds		Petersen Health Care Companies	0.00%	607	607 13
14	Total		\$			\$ 13,972	\$ * 13,972 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377Report Period Beginning: 01/01/02Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	35 Rent - Equipment & Vehicles	\$	Petersen Health Care Companies	0.00%	\$ 92	\$ 92	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$			\$ 92	\$ *	92 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

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Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Eddie Franciskovich	Administrator	Administrative	50.00	0	40	100.00	Salary	\$ 43,750	L17C.1	1
2			See page 6 ownership schedule								2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 43,750		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center # 0045377 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Petersen Health Care Companies
 Street Address 7218 North Villa Lake
 City / State / Zip Code Peoria, IL 61614
 Phone Number (309) 691-8113
 Fax Number (309) 691-8622

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	\$ 3,858	\$ 6,033	\$ 101	1
2	6	Maintenance Supplies	Patient Days	229,422	11	6,877	6,033	181	2
3	19	Professional Services	Patient Days	229,422	11	84,471	6,033	2,221	3
4	20	Dues, Fees & Subscriptions	Patient Days	229,422	11	5,163	6,033	136	4
5	21	Clerical and General Office	Patient Days	229,422	11	115,931	6,033	3,049	5
6	22	Employee Benefits	Patient Days	229,422	11	132,243	6,033	3,478	6
7	23	Inservice Training	Patient Days	229,422	11	4,287	6,033	113	7
8	24	Travel & Seminars	Patient Days	229,422	11	10,813	6,033	284	8
9	25	Other Admin. Staff Transport	Patient Days	229,422	11	10,154	6,033	267	9
10	26	Insurance	Patient Days	229,422	11	15,558	6,033	409	10
11	30	Depreciation	Patient Days	229,422	11	59,343	6,033	1,561	11
12	32	Interest	Patient Days	229,422	11	59,511	6,033	1,565	12
13	34	Rent - Facility & Grounds	Patient Days	229,422	11	23,100	6,033	607	13
14	35	Rent - Equipment & Vehicles	Patient Days	229,422	11	3,511	6,033	92	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$ 534,820	\$		\$ 14,064	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Bank of Farmington		x	Van	\$997.00	12/18/01	\$ 59,816	\$ 41,835	1/17/07	0.0690	\$ 3,325	1							
2												2							
3												3							
4												4							
5												5							
	Working Capital																		
6	Farmers and Merchants State Bank	x		Revolving credit	NA	10/15/02	100,000	64,500	10/15/02	0.0700	890	6							
7	James Petersen	x		Working capital	Interest	09/10/02	50,000	50,000	Various	Prime	6,134	7							
8	James Petersen	x		Long term operating loan	NA	7/31/02	487,211	481,128	Various	Prime		8							
9	TOTAL Facility Related				\$997.00		\$ 697,027	\$ 637,463			\$ 10,349	9							
	B. Non-Facility Related*																		
10	Allocated from management company										1,565	10							
11												11							
12												12							
13												13							
14	TOTAL Non-Facility Related						\$	\$			\$ 1,565	14							
15	TOTALS (line 9+line14)						\$ 697,027	\$ 637,463			\$ 11,914	15							

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ NA Line #

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **Prairie City Health Care Center**# **0045377** Report Period Beginning: **01/01/02** Ending: **12/31/02****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

		Important , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.		
1. Real Estate Tax accrual used on 2001 report.			\$	3,632 1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	3,806 2
3. Under or (over) accrual (line 2 minus line 1).			\$	174 3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	3,921 4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$	4,095 7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997		8	
	1998		9	
	1999		10	
	2000	3,673	11	
	2001	3,806	12	
				FOR OHF USE ONLY
				13 FROM R. E. TAX STATEMENT FOR 2001 \$ 13
				14 PLUS APPEAL COST FROM LINE 5 \$ 14
				15 LESS REFUND FROM LINE 6 \$ 15
				16 AMOUNT TO USE FOR RATE CALCULATION \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Prairie City Health Care Center COUNTY McDonough

FACILITY IDPH LICENSE NUMBER 0045377

CONTACT PERSON REGARDING THIS REPORT Edward Franciskovich

TELEPHONE (309) 775-3313 FAX #: (309) 775-3311

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>15-000-22-05</u>	<u>Facility - ground</u>	\$ <u>3,806.00</u>	\$ <u>3,806.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
TOTALS		\$ <u>3,806.00</u>	\$ <u>3,806.00</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:

17,500

B. General Construction Type:

Exterior

Brick

Frame

Cinderblock

Number of Stories

1 floor

C. Does the Operating Entity?

☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES
 ☐ NO

If so, please complete the following:

1. Total Amount Incurred:

6,825

2. Number of Years Over Which it is Being Amortized:

5

3. Current Period Amortization:

1,366

4. Dates Incurred:

2001

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Land	216,058	2001	\$ 9,000	1
2					2
3	TOTALS	216,058		\$ 9,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center# 0045377

Report Period Beginning:

01/01/02

Ending:

12/31/02**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	48		2001	1970	\$ 53,000	\$ 1,359	39	\$ 1,359	\$	\$ 2,038	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Sewer hook up		2001		2,894	74	39	74		111	9
10	Architectural design and consultation		2002		2,903	74	39	74		74	10
11	Roofing materials		2002		878	14	39	13	(1)	13	11
12	2 new bathrooms		2002		13,854	222	39	207	(15)	207	12
13	Install new grease trap		2002		1,318	21	39	20	(1)	20	13
14	Floor tiles and carpeting		2002		7,578	105	39	97	(8)	97	14
15	Sprinkler heads		2002		2,649	37	39	34	(3)	34	15
16	Architectural design and consultation		2002		10,792	150	39	139	(11)	139	16
17	upgrade bathroom and shower facilities		2002		3,370	40	39	36	(4)	36	17
18	Architectural design and consultation		2002		500	4	39	3	(1)	3	18
19	Lighting fixtures and wallpaper		2002		4,097	22	39	18	(4)	18	19
20	Ceiling tiles		2002		2,152	34	39	32	(2)	32	20
21	Hardwood items		2002		1,771	28	39	26	(2)	26	21
22	Building materials		2002		728	9	39	8	(1)	8	22
23	Upgrade drainage system		2002		1,067	13	39	11	(2)	11	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37			\$	\$		\$	\$		37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 109,551	\$ 2,206		\$ 2,151	\$ (55)	\$ 2,867	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 69,425	\$ 16,214	\$ 10,332	\$ (5,882)	5,7	\$ 15,028	71
72	Current Year Purchases	10,292	1,908	972	(936)	5,7	972	72
73	Fully Depreciated Assets							73
74	Allocated from management company			1,561	1,561			74
75	TOTALS	\$ 79,717	\$ 18,122	\$ 12,865	\$ (5,257)		\$ 16,000	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility	2001 Chevy Van	2001	\$ 50,473	\$ 12,248	\$ 10,095	\$ (2,153)	5	\$ 15,142	76
77										77
78										78
79										79
80	TOTALS			\$ 50,473	\$ 12,248	\$ 10,095	\$ (2,153)		\$ 15,142	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 248,741	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 32,576	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 25,111	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ (7,465)	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 34,009	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Truck; 2001	\$ 28,915	\$ 4,165	\$ 6,205	86
87	Beauty shop equipment	920	131	131	87
88					88
89					89
90					90
91	TOTALS	\$ 29,835	\$ 4,296	\$ 6,336	91

G. Construction-in-Progress

	Description	Cost	
92	NA		92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: NA
 2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
 If NO, see instructions. ☐ YES ☒ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5	Allocation from management company				607			5
6								6
7	TOTAL				\$ 607			7

8. List separately any amortization of lease expense included on page 4, line 34. NA
 This amount was calculated by dividing the total amount to be amortized NA
 by the length of the lease NA.

9. Option to Buy: ☐ YES ☐ NO Terms: NA *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
 16. Rental Amount for movable equipment: \$ 1,307 Description: Allocation from management company \$92, Copy machine \$1215
 (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	NA		\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:
 Beginning NA
 Ending NA

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	<u>/2003</u>	\$ <u>NA</u>
13.	<u>/2004</u>	\$ <u>NA</u>
14.	<u>/2005</u>	\$ <u>NA</u>

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE _____	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE _____
---	---	--

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$ **NA**

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
					1	Licensed Occupational Therapist	NA	hrs	\$		
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$		14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 8,738	\$ 8,738	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	117,142	117,142	3
4	Supply Inventory (priced at)	3,278	3,278	4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 129,158	\$ 129,158	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	9,000	9,000	13
14	Buildings, at Historical Cost	53,000	53,000	14
15	Leasehold Improvements, at Historical Cost	56,551	56,551	15
16	Equipment, at Historical Cost	160,026	160,026	16
17	Accumulated Depreciation (book methods)	(74,668)	(74,668)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	6,826	6,826	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(2,161)	(2,161)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 208,574	\$ 208,574	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 337,732	\$ 337,732	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 16,271	\$ 16,271	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,456	14,456	28
29	Short-Term Notes Payable	123,878	123,878	29
30	Accrued Salaries Payable	27,415	27,415	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	3,921	3,921	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	<u>Accrued ins - general</u>	1,493	1,493	36
37	<u>Other accrued expenses</u>	6,198	6,198	37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 193,632	\$ 193,632	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	513,639	513,639	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 513,639	\$ 513,639	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 707,271	\$ 707,271	46
47	TOTAL EQUITY(page 18, line 24)	\$ (369,539)	\$ (369,539)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 337,732	\$ 337,732	48

SEE ACCOUNTANTS' COMPILATION REPORT

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (126,764)	1
2	Restatements (describe):		2
3	Restatement of prior year balances	(21,108)	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (147,872)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(221,667)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (221,667)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (369,539)	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

VII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 788,731	1
2	Discounts and Allowances for all Levels	()	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 788,731	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Vending machine, \$749; Misc, \$2032	2,781	28
28a	Loss on sale of fixed assets	(4,071)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ (1,290)	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 787,441	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	278,537	31
32	Health Care	409,600	32
33	General Administration	242,446	33
	B. Capital Expense		
34	Ownership	78,525	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,009,108	40
41	Income before Income Taxes (line 30 minus line 40)**	(221,667)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (221,667)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Prairie City Health Care Center# 0045377Report Period Beginning: 01/01/02Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	2,480	2,480	\$ 34,185	\$ 13.78	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,536	2,577	36,582	14.20	3
4	Licensed Practical Nurses	6,452	6,593	89,532	13.58	4
5	Nurse Aides & Orderlies	24,653	25,195	177,668	7.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,400	2,480	18,000	7.26	9
10	Activity Assistants	2,004	2,004	13,772	6.87	10
11	Social Service Workers	2,400	2,480	18,500	7.46	11
12	Dietician					12
13	Food Service Supervisor	2,424	2,480	18,200	7.34	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,438	9,667	57,381	5.94	15
16	Dishwashers					16
17	Maintenance Workers	2,600	2,600	21,010	8.08	17
18	Housekeepers	7,424	7,564	43,776	5.79	18
19	Laundry	1,941	2,016	8,016	3.98	19
20	Administrator	2,480	2,480	43,750	17.64	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	440	440	5,583	12.69	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	69,672	71,056	\$ 585,955 *	\$ 8.25	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	24	\$ 1,936	L1, C3	35
36	Medical Director				36
37	Medical Records Consultant	15	227	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	38	1,800	L10, C3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	25	506	L11, C3	44
45	Social Service Consultant	25	506	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	127	\$ 4,975		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ NA		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number **Prairie City Health Care Center**# **0045377**Report Period Beginning: **01/01/02**Ending: **12/31/02**

XIX. SUPPORT SCHEDULES

A. Administrative Salaries		Ownership	Amount	D. Employee Benefits and Payroll Taxes		Amount	F. Dues, Fees, Subscriptions and Promotions		
Name	Function	%		Description			Description	Amount	
Eddie Franciskovich	Administrator	50	\$ 43,750	Workers' Compensation Insurance	\$ 16,653		IDPH License Fee	\$	
Carolyn Peterson		50	0	Unemployment Compensation Insurance	5,840		Advertising: Employee Recruitment	1,141	
				FICA Taxes	44,191		Health Care Worker Background Check (Indicate # of checks performed _____)		
				Employee Health Insurance	37,338		IL Health Care Assoc	1,574	
				Employee Meals	0		Various Dues	244	
				Illinois Municipal Retirement Fund (IMRF)*	0		Allocated from management company	136	
				Employee relations	2,496				
				Allocated from management company	3,478				
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			\$ 43,750	TOTAL (agree to Schedule V, line 22, col.8)		\$ 109,996	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 3,095
B. Administrative - Other							Less: Public Relations Expense ()		
Description			Amount				Non-allowable advertising ()		
			\$				Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$	E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**		
C. Professional Services			Amount	Description	Line #	Amount	Description	Amount	
Vendor/Payee	Type								
Ginoli & Co	Accounting		\$ 1,556	NA		\$	Out-of-State Travel	\$	
Claudon, Barnhart, and Beal	Legal		1,053						
America Online	Computer Services		175				In-State Travel	1,083	
ADP	Computer Services		5,248						
LTC Solutions	Computer Services		1,320						
IDPA (eliminated in Col 5)	Provider Assessments		26,280				Seminar Expense	175	
Petersen Development Co	Management Fees		11,000				Allocated from management company	284	
							Entertainment Expense ()		
							(agree to Sch. V, line 24, col. 8)		
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)			\$ 46,632	TOTAL		\$	TOTAL	\$ 1,542	

* Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT

**See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1 Improvement Type	2 Month & Year Improvement Was Made	3 Total Cost	4 Useful Life	5	6	7	8	9	10	11	12	13
					Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	NA		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Prairie City Health Care Center

STATE OF ILLINOIS

0045377

Report Period Beginning:

01/01/02

Ending:

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XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Illinois Health Care Association \$1574
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? NA
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? NA
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.5 yrs
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 3,507 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No
If YES, give effective date of lease. NA
- (9) Are you presently operating under a sublease agreement? YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 26,280
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ NA Has any meal income been offset against related costs? No Indicate the amount. \$ NA
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ NA
c. What percent of all travel expense relates to transportation of nurses and patients? NA
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? NA
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. \$ NA
- (17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: NA The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? NA If no, please explain. NA
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? NA
Attach invoices and a summary of services for all architect and appraisal fees.

Prairie City Health Care Center

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Detail Schedules

Part V, Schedule C, Line 27

General Administration - Other

Charitable contributions	\$	625
Special events		670
Bank charges		35
Service fees		144
Interest expense		8,948
Total per general ledger	\$	10,422
Less interest expense reclassified		(8,948)
Less unallowable costs reclassified		
Charitable contributions		(625)
Special events		(670)
Total after reclassifications	\$	179

Part V, Schedule C, Line 36

Capital Expense - Other

General insurance	\$	31,289
Auto insurance		2,377
Total per general ledger	\$	33,666
Less insurance reclassified		(33,666)
Total after reclassifications	\$	-

Part VI, Schedule C, Line 45

	Amount	Line
Telephone in patient rooms	\$ 763	21
Sales tax	174	1
Charitable contributions	625	27
Promotional advertising	8,857	20
Special events	670	27
Non-care auto depreciation	4,165	30
	<u>\$ 15,254</u>	

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center

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Ownership Schedule and Related Parties

Part VII, Schedule A, Column 1, Page 6

Ownership Schedule

	<u>01/01/2002 - 07/31/2002.</u>	<u>08/01/2002 - 12/31/2002.</u>
Carolyn Petersen	40%	50%
Eddie Franciskovich	40%	50%
Mark Petersen	20%	0%

Part VII, Schedule A, Column 2, Page 6

Related Parties

Related Nursing Home

Robings Manor Nursing Home
Countryview Terrace
Sunset Manor Nursing Home
Kewanee Care Home
Arcola Health Care Center
Eastview Terrace
Havana Health Care Center
Prairie City Health Care Center

City

Brighton, IL
Louisville, IL
Canton, IL
Kewanee, IL
Arcola, IL
Sullivan, IL
Havana, IL
Prairie City, IL

Out of State Nursing Home

Friendly Village
Horizons Unlimited
Taylor Park
Passport
Meadow Lawn Nursing Center
Cumberland Heights - Tomahawk
Maple Park
Opportunities Unlimited (Workshop setup-no beds)

City

Rhineland, WI
Rhineland, WI
Rhineland, WI
Rhineland, WI
Davenport, IA
Tomahawk, WI
Rhineland, WI

Part VII, Schedule A, Column 3, Page 6

Other Related Business Entities

Petersen Health Care Companies
Petersen Property

Peoria, IL
Canton, IL

Management/Bookkeeping
Building - Sunset Manor

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center

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Reclassification Entries

To Reclassify Loan Interest

PG3, Line 27 General Administration - Other		\$	8,948
PG4, Line 32 Interest	\$	8,948	

To Reclassify Equipment Rental

PG3, Line 4 Laundry - Other			313
PG3, Line 5 Heat and Other Utilities	223		
PG3, Line 35 Equipment Rental	90		

To Reclassify Provider Participation Fees

PG3, Line 19 Professional Services - Other			26,280
PG4, Line 42 Provider Participation Fees	26,280		

To Reclassify Property and Auto Insurance

PG4, Line 36 Other			33,666
PG3, Line 36 Insurance - Property, Liability, Malpractice	33,666		

To Reclassify Nonallowable Expenses

	Amount	Line
Beauty Shops	\$ 131	30
Other		
Telephone in Patient Rooms	763	21
Sales Tax	174	1
Contributions	625	27
Advertising	8,857	20
Special Events	670	27
NonCare Auto (Depreciation)	4,165	30
Nonallowable	<u>\$ 15,385</u>	<u>43</u>

SEE ACCOUNTANT'S COMPILATION REPORT

Prairie City Health Care Center

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Reconciliation to Taxable Income

Income (Loss) per Books	\$ (221,667)
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Expenses recorded on books not deducted on return	
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Charitable Contributions	625
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Taxable Income, per Federal Tax Return	<u>\$ (221,042)</u>
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SEE ACCOUNTANT'S COMPILATION REPORT